CALIFORNIA CODE OF REGULATIONS
TITLE 22, DIVISION 7, CHAPTER 10 - HEALTH FACILITY DATA

Article 8. Discharge Data Reporting Requirements

97210. Notice of Change in Hospital Operations, Contact Person, Method of Submission or Designated Agent.

(a) Each hospital shall notify the Office's Discharge Data Program in writing within 30 days after any change in the person designated as the patient discharge contact person or in the telephone number of the contact person.

(b) Each hospital shall notify the Office's Discharge Data Program in writing within 30 days after any change in method of submission ~~(Manual Abstract Reporting Form (OSHPD 1370), computer tape (reel or cartridge) or diskette~~ or *change in* designated agent for the purpose of submitting the hospital's discharge data report. If there is a change in designated agent, the hospital or its new *designated* agent must comply with Section 97215. A hospital may submit its own discharge data report directly to the Office's Discharge Data Program, or it may designate an agent for this purpose.

(c) Each hospital beginning or resuming operations, whether in a newly constructed facility or in an existing facility, shall notify the Office's Discharge Data Program within 30 days after its first day of operation of its: designated agent for the purpose of submitting the hospital's discharge data report (if it chooses not to submit its discharge data report directly), method of submission ~~(Manual Abstract Reporting Form (OSHPD 1370), computer tape (reel or cartridge) or diskette)~~, contact person, and telephone number of contact person. The hospital shall be provided a unique identification number that it can report pursuant to Section 97239. Pursuant to Section 97215, the hospital, if it chooses to designate itself to submit its discharge data report, and its method of submission is not Manual Abstract Reporting Form (OSHPD 1370), shall submit a set of test data that is in compliance with the required format. Pursuant to Section 97215, any agent the hospital designates to submit its discharge data report on its behalf must have submitted a test set of data that is in compliance with the required format, prior to the due date of the hospital's first reporting period.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

~~97212. Definitions, as used in this Article.~~

~~This section, as adopted October 14, 1993, applies to discharges prior to and including December 31, 1996. For Section 97212 applicable to discharges occurring on and after January 1, 1997, see below.~~

(a) California Hospital Discharge Data Set. The California Hospital Discharge Data Set consists of the seventeen data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code.

(b) Designated Agent. Examples of possible designated agents include the hospital's abstractor, a data processing firm, or the data processing unit in the corporate office of the hospital.

(c) Discharge. A discharge is defined as a newborn or a person who was formally admitted to a hospital as an inpatient for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer, and who is discharged under one of the following circumstances:

(1) is formally discharged from the care of the hospital and leaves the hospital,

(2) transfers within the hospital from one level of care to another level of care, as defined by Subsection (g) of Section 97212, or

(3) has died.

(d) DRG. Diagnosis Related Groups is a classification scheme with which to categorize patients according to clinical coherence and expected resource intensity, as indicated by their diagnoses, procedures, age, sex, and disposition, and was established and is revised annually by the U.S. Health Care Financing Administration.

(e) DSM-III-R. Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised, as produced by and available from the American Psychiatric Association, Washington, D.C.

(f) ICD-9-CM. The International Classification of Diseases, 9th Revision, Clinical Modification, published by the U.S. Department of Health and Human Services. Coding guidelines and annual revisions to ICD-9-CM are made nationally by the "cooperating parties" (the American Hospital Association, the Health Care Financing Administration, the National Center for Health Statistics, and the American Health Information Management Association).

(g) Level of Care. Level of care is defined as one of the following:

(1) Skilled nursing/intermediate care. Skilled nursing/intermediate care is inpatient care that is provided to inpatients occupying beds appearing on the hospital's license in the classifications of skilled nursing or intermediate care, as defined by Subdivisions (b), (c), or (d), of Section 1250.1 of the Health and Safety Code. Skilled nursing/intermediate care also means inpatient care that is provided to inpatients occupying general acute care beds that are being used to provide skilled nursing/intermediate care to those inpatients in an approved swing bed program.

(2) Rehabilitation care. Rehabilitation care means inpatient care that is provided to inpatients occupying beds included on a hospital's license within the general acute care classification, and designated as rehabilitation center beds, as defined by Subsection (a) of Section 70034 of Title 22, California Code of Regulations.

~~(3) Psychiatric care. Psychiatric care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license as acute psychiatric beds, as defined by Subdivision (e) of Section 1250.1 of the Health and Safety Code.~~

~~(4) Acute care. Acute care means all other types of inpatient care provided to inpatients occupying all other types of licensed beds in a hospital.~~

~~(h) Licensee. Licensee means an entity that has been issued a license to operate a hospital, as defined by Subdivision (c) of 128700 of the Health and Safety Code.~~

~~(i) Record. A record is defined as the set of seventeen data elements of the "hospital discharge abstract data record" as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for one patient.~~

~~(j) Report. A report is defined as the collection of all records submitted by a hospital for a semiannual reporting period, or for a shorter period pursuant to Subsection (b) of Section 97211.~~

~~Authority: Section 128810, Health and Safety Code.~~
~~Reference: Sections 128735, 1250, and 1250.1, Health and Safety Code.~~

97212. Definitions, as used in this Article.

~~This section, as amended effective August 14, 1996, applies to discharges on and after January 1, 1997. For Section 97212 applicable to discharges occurring prior to and including December 31, 1996, see above.~~

(a) California Hospital Discharge Data Set. The California Hospital Discharge Data Set consists of the data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code.

(b) Computer Media. Computer media means computer tape (reel or cartridge), diskette, or compact disk.

(b*c*) Designated Agent. ~~Examples of possible designated agents include~~ *An entity designated by a hospital to submit that hospital's discharge data records to the Office's Discharge Data Program; may include* the hospital's abstractor, a data processing firm, or the data processing unit in the *hospital's* corporate office ~~of the hospital~~.

(~~c~~*d*) Discharge. A discharge is defined as a newborn or a person who was formally admitted to a hospital as an inpatient for observation, diagnosis, or treatment, with the expectation of remaining overnight or longer, and who is discharged under one of the following circumstances:

(1) is formally discharged from the care of the hospital and leaves the hospital,

(2) transfers within the hospital from one type of care to another type of care, as defined by Subsection (g*i*) of Section 97212, or

(3) has died.

(de) DRG. Diagnosis Related Groups is a classification scheme with which to categorize patients according to clinical coherence and expected resource intensity, as indicated by their diagnoses, procedures, age, sex, and disposition, and was established and is revised annually by the U.S. Health Care Financing Administration.

(ef) ~~DSM-III-R. Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised, as produced by and available from the American Psychiatric Association, Washington, D.C.~~ *Do Not Resuscitate (DNR) Order. A DNR order is a directive from a physician in a patient's current inpatient medical record instructing that the patient is not to be resuscitated in the event of a cardiac or pulmonary arrest. In the event of a cardiac or pulmonary arrest, resuscitative measures include, but are not limited to, the following: cardiopulmonary resuscitation (CPR), intubation, defibrillation, cardioactive drugs, or assisted ventilation.*

(fg) ICD-9-CM. The International Classification of Diseases, 9th Revision, Clinical Modification, published by the U.S. Department of Health and Human Services. Coding guidelines and annual revisions to ICD-9-CM are made nationally by the "cooperating parties" (the American Hospital Association, the Health Care Financing Administration, the National Center for Health Statistics, and the American Health Information Management Association).

(h) Method of Submission. A method of submission is the medium used by a hospital or its designated agent to submit a discharge data report to the Office and may be one of the following:

(1) computer tape (reel or cartridge),

(2) diskette,

(3) compact disk, or

(4) Manual Abstract Reporting Form (OSHPD 1370).

(gi) Type of Care. Type of care is defined as one of the following:

(1) Skilled nursing/intermediate care. Skilled nursing/intermediate care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classifications of skilled nursing or intermediate care, as defined by Subdivisions (a)(2), (a)(3), or (a)(4), of Section 1250.1 of the Health and Safety Code. Skilled nursing/intermediate care also means inpatient care that is provided to inpatients occupying general acute care beds that are being used to provide skilled nursing/intermediate care to those inpatients in an approved swing bed program.

(2) Physical rehabilitation care. Physical rehabilitation care means inpatient care that is provided to inpatients occupying beds included on a hospital's license within the general acute care classification, as defined by Subdivision (a)(1) of Section 1250.1 of the Health and Safety Code, and designated as rehabilitation center beds, as defined by Subsection (a) of Section 70034 and of Section 70595 ~~of Title 22, California Code of Regulations~~.

(3) Psychiatric care. Psychiatric care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license in the classification of acute psychiatric beds, as defined by Subdivision (a)(5) of Section 1250.1 of the Health and Safety Code, and psychiatric health facility, as defined by Subdivision (a) of Section 1250.2 of the Health and Safety Code.

(4) Chemical dependency recovery care. Chemical dependency recovery care means inpatient care that is provided to inpatients occupying beds appearing on a hospital's license as chemical dependency recovery beds, as defined by Subdivision (a)(7) of Section 1250.1 and Subdivisions (a), (c), or (d) of Section 1250.3 of the Health and Safety Code.

(5) Acute care. Acute care, *as* defined by Subdivision (a)(1) of Section 1250.1 of the Health and Safety Code, means all other types of inpatient care provided to inpatients occupying all other types of licensed beds in a hospital, other than *those* ~~specified in~~ *defined by* Subsections (g*i*)(1), (g*i*)(2), (g*i*)(3), and (g*i*)(4) of *this* Section *section* ~~97212 of Title 22, California Code of Regulations~~.

(h*j*) Licensee. Licensee means an entity that has been issued a license to operate a hospital, as defined by Subdivision (c) of Section 128700 of the Health and Safety Code.

(i*k*) Record. A record is defined as the set of data elements of the "hospital discharge abstract data record," as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for one patient.

(j*l*) Report. A report is defined as the collection of all records submitted by a hospital for a semiannual reporting period or for a shorter period, pursuant to Subsection (b) of Section 97211.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735, 1250, and 1250.1, Health and Safety Code.

~~97213. Required Reporting.~~

~~This section, as adopted October 14, 1993, applies to discharges prior to and including December 31, 1996. For Section 97213 applicable to discharges occurring on and after January 1, 1997, see below.~~

~~(a) Each hospital shall submit the seventeen data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for each inpatient discharged during the semiannual reporting period, according to the format specified in Section 97215 and by the dates specified in Section 97211.~~

~~(b) For discharges on or after January 1, 1995, a hospital shall separately identify records of patients being discharged from the skilled nursing/intermediate care level of care, as defined by Subsection (g)(1) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by placing them in a separate collection of abstracting forms. Each separate collection of abstracting forms shall have an accompanying transmittal form, pursuant to Section 97214, that shall identify the collection of abstracting forms~~

as being from the skilled nursing/intermediate care level of care. If submitted on computer diskette, the hospital shall identify these records by placing them on a separate diskette, and identifying their level of care on the accompanying transmittal form submitted pursuant to Section 97214. If submitted on computer tape (reel or cartridge), the hospital shall identify these records by recording a "3" in the first position on each of these records.

(c) For discharges on or after January 1, 1995, a hospital shall separately identify records of patients being discharged from the rehabilitation level of care, as defined by Subsection (g)(2) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by placing them in a separate collection of abstracting forms. Each separate collection of abstracting forms shall have an accompanying transmittal form, pursuant to Section 97214, that shall identify the collection of abstracting forms as being from the rehabilitation level of care. If submitted on computer diskette, the hospital shall identify these records by placing them in a separate diskette, and identifying their level of care on the accompanying transmittal form. If submitted on computer tape (reel or cartridge), the hospital shall identify these records by recording a "6" in the first position on each of these records.

(d) For discharges on or after January 1, 1995, hospitals submitting records on computer tape (reel or cartridge) shall put a "1" in the first position on each record not identified with a "3" (pursuant to Subsection (b) of Section 97213) or a "6" (pursuant to Subsection (c) of Section 97213). Hospitals submitting discharge records on computer tape may combine all levels of care on the same tape.

(e) A hospital operating under a consolidated license may submit its discharge data report in separate sets of records that relate to separate physical plants.

(f) If a hospital submits its discharge data report in separate sets of records, the compilation of those sets must include all discharge records from all levels of care and from all physical plants on that hospital's license. The complete compilation of sets of records for a hospital comprises that hospital's report for purposes of this Article.

Authority: Section 129810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97213. Required Reporting.

This section, as amended effective August 14, 1996, applies to discharges on and after January 1, 1997. For Section 97213 applicable to discharges occurring prior to and including December 31, 1996, see above.

(a) Each hospital shall submit the data elements of the hospital discharge abstract data record, as specified in Subdivision (g) of Section 128735 of the Health and Safety Code, for each inpatient discharged during the semiannual reporting period, according to the format specified in Section 97215 and by the dates specified in Section 97211.

(b) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the acute care type of care, as defined by Subsection (g*i*)(5) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "1" in the space provided. If submitted on computer ~~tape (reel or cartridge) or diskette~~ *media*, the hospital shall identify these records by recording a "1" in the first position on each of these records.

(c) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the skilled nursing/intermediate care type of care, as defined by Subsection (g*i*)(1) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "3" in the space provided. If submitted on computer ~~tape (reel or cartridge) or diskette~~ *media*, the hospital shall identify these records by recording a "3" in the first position on each of these records.

(d) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the psychiatric care type of care, as defined by Subsection (g*i*)(3) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "4" in the space provided. If submitted on computer ~~tape (reel or cartridge) or diskette~~ *media*, the hospital shall identify these records by recording a "4" in the first position on each of these records.

(e) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the chemical dependency recovery care type of care, as defined by Subsection (g*i*)(4) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "5" in the space provided. If submitted on computer ~~tape (reel or cartridge) or diskette~~ *media*, the hospital shall identify these records by recording a "5" in the first position on each of these records.

(f) For discharges on or after January 1, 1997, a hospital shall separately identify records of patients being discharged from the physical rehabilitation care type of care, as defined by Subsection (g*i*)(2) of Section 97212. The method of identification depends on the method the hospital has chosen to submit these records. If submitted on Manual Abstract Reporting Forms (OSHPD 1370), the hospital shall identify these records by recording a "6" in the space provided. If submitted on computer ~~tape (reel or cartridge) or diskette~~ *media*, the hospital shall identify these records by recording a "6" in the first position on each of these records.

(g) ~~Hospitals submitting discharge records on Manual Abstract Reporting Forms (OSHPD 1370) or diskette shall combine all types of care using one transmittal form. Hospitals submitting discharge records on computer tape (reel or cartridge) shall combine all types of care on the same tape.~~ *Each discharge data report shall be submitted at one time, use one method of submission, and shall include all types of care.*

(h) A hospital operating under a consolidated license may submit its discharge data report in separate sets of records that relate to separate physical plants.

(i) If a hospital operating under a consolidated license submits its report in separate sets of records, the compilation of those sets must include all discharge records from all types of care and from all physical plants on that hospital's license. The complete compilation of sets of records for a hospital comprises that hospital's discharge data report for purposes of this Article.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97214. Form of Authentication.

This section, as adopted October 14, 1993, applies to discharges prior to and including December 31, 1996. For Section 97214 applicable to discharges occurring on and after January 1, 1997, see below.

(a) Hospitals submitting their hospital discharge abstract data records using the Manual Abstract Reporting Forms (OSHPD 1370) must submit, with each separate collection of discharge abstract data forms, a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, the hospital identification number as defined by Section 97239, the reporting period's beginning and ending dates, the number of records, and the following statement of certification, to be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information the accompanying discharge abstract data records are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: _____

_____
(Name of hospital)

By: _____

Title: _____

Address: _____

A hospital that uses the Individual Hospital Transmittal Form (OSHPD 1370.1) is not required to submit a separate Discharge Data Certification Form (OSHPD 1370.3).

(b) Hospitals submitting their hospital discharge abstract data records using computer media, rather than the Manual Abstract Reporting Forms (OSHPD 1370), must submit with each

computer tape (reel or cartridge) or diskette a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, the hospital identification number (as described in Section 97239), the reporting period's beginning and ending dates, the number of records, the tape specifications (if a tape), and the signed statement of certification as defined by Subsection (a) of Section 97214. Hospitals submitting more than one discharge data report on a single computer tape (reel or cartridge) shall specify on the Individual Hospital Transmittal Form (OSHPD 1370.1), separately for each report on the tape, the hospital identification number, the reporting period's beginning and ending dates, and the number of records.

(c) Hospitals that designate an agent to submit their hospital discharge abstract data records must submit a Discharge Data Certification Form (OSHPD 1370.3) to the Office's Discharge Data Program. This form shall be mailed after the end of each reporting period, and before that corresponding reporting period's due date. The certification must cover the same reporting period as the data submitted by the designated agent. This form, that contains the following statement of certification, shall be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information the discharge abstract data records submitted to (name of my hospital's designated agent) for the period from (starting date) to (ending date) are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: _____

_____
(Name of hospital)

By: _____

Title: _____

Address: _____

(d) Agents who have been designated by a hospital through the Discharge Data Certification Form (OSHPD 1370.3) to submit that hospital's discharge abstract data records must submit with each computer tape (reel or cartridge) or diskette a completed Agent's Transmittal Form (OSHPD 1370.2), including the following information clearly indicated: the tape specifications (if a tape), the hospital name, the hospital identification number, the reporting period's beginning and ending dates, and the number of records. If the computer tape (reel or cartridge) contains more than 13 reports, page two of the Agent's Transmittal Form (OSHPD 1370.2) shall be completed and attached to page one.

Designated agents are not required to submit any certification forms.

(e) Any hospital or designated agent may obtain free copies of the Hospital Transmittal Form

(OSHPD 1370.1), the Agent's Transmittal Form (1370.2), and the Discharge Data Certification Form (1370.3) by contacting the Office's Discharge Data Program.

Authority: Section 128810, Health and Safety Code.

Reference: Section 128735, Health and Safety Code.

97214. Form of Authentication.

This section, as amended effective August 14, 1996, applies to discharges on and after January 1, 1997. For Section 97214 applicable to discharges occurring prior to and including December 31, 1996, see above.

(a) Hospitals submitting their hospital discharge abstract data records using the Manual Abstract Reporting Forms (OSHPD 1370) must submit *with each discharge data report* a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, the hospital identification number, as described *specified* in Section 97239, the reporting period's beginning and ending dates, the number of records, and the following statement of certification, to be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information, the accompanying discharge abstract data records are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: _____ _____
(Name of hospital)

By: _____

Title: _____

Address: _____

A hospital that uses the Individual Hospital Transmittal Form (OSHPD 1370.1) is not required to submit a separate Discharge Data Certification Form (OSHPD 1370.3).

(b) Hospitals submitting their hospital discharge abstract data records using computer media, rather than the Manual Abstract Reporting Form (OSHPD 1370), must submit with each *discharge data report* computer tape (reel or cartridge) or diskette a completed Individual Hospital Transmittal Form (OSHPD 1370.1), including the following information: the hospital name, the hospital identification number, (as described *specified* in Section 97239), the reporting period's beginning and ending dates, the number of records, the tape specifications (if a tape), and the signed statement of certification, as defined by *specified in* Subsection (a) of Section 97214.

(c) Hospitals that designate an agent to submit their hospital discharge abstract data records

must submit *for each discharge data report* a Discharge Data Certification Form (OSHPD 1370.3) to the Office's Discharge Data Program. This form shall be mailed after the end of each reporting period, and before that corresponding reporting period's due date. The certification must cover the same reporting period as the data submitted by the designated agent. This form, that contains the following statement of certification, shall be signed by the hospital administrator or his/her designee:

I, (name of individual), certify under penalty of perjury as follows:

That I am an official of (name of hospital) and am duly authorized to sign this certification; and that, to the extent of my knowledge and information, the discharge abstract data records submitted to (name of my hospital's designated agent) for the period from (starting date) to (ending date) are true and correct, and that the definitions of the data elements required by Subdivision (g) of Section 128735 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this hospital.

Dated: _____ _____
(Name of hospital)

By: _____

Title: _____

Address: _____

(d) Agents who have been designated by a hospital through the Discharge Data Certification Form (OSHPD 1370.3) to submit that hospital's discharge abstract data records must submit with each *discharge data report* ~~computer tape (reel or cartridge) or diskette~~ a completed Agent's Transmittal Form (OSHPD 1370.2), including the following information clearly indicated: the hospital name, the hospital identification number, the reporting period's beginning and ending dates, the number of records, and the tape specification*s* ~~(if a tape)~~. If the computer tape ~~(reel or cartridge)~~ contains more than 13 reports, page two of the Agent's Transmittal Form (OSHPD 1370.2) shall be completed and attached to page one.

Designated agents are not required to submit any certification forms.

(e) Any hospital or designated agent may obtain free copies of the Individual Hospital Transmittal form (OSHPD 1370.1*)*, the Agent's Transmittal Form (OSHPD 1370.2), and the Discharge Data Certification Form (OSHPD 1370.3) by contacting the Office's Discharge Data Program.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97215. Format.

Patient discharge data shall be reported to the Office's Discharge Data Program on either the

Manual Abstract Reporting Form (OSHPD 1370) or on computer ~~tape (reel or cartridge) or diskette~~ *media*. The version of the Manual Abstract Reporting Form (OSHPD 1370) to be used depends on the date of discharge: ~~discharges January 1, 1996 through December 31, 1996 shall use Form 1370 as revised May 1995 and~~ discharges ~~on and after~~ January 1, 1997*, through December 31, 1998,* shall use Form 1370 as revised June 1996*, and discharges on or after January 1, 1999, shall use Form 1370 as revised in March 1998*. The Office shall furnish each hospital using Form 1370 ~~sufficient copies~~ *a copy* of the appropriate version in advance of the start of each reporting period. *Additional copies of Form 1370 shall be made by the hospital to submit its discharge data and each additional copy shall be made on one sheet, front (Page 1 of 2) and back (Page 2 of 2).*

The format and specifications for the computer ~~tape (reel or cartridge) or diskette~~ *media* depend on the date of discharge: ~~computer tape (reel or cartridge) or diskette containing discharges occurring January 1, 1996 through December 31, 1996 shall comply with the Office's standard format and specifications as updated August 1995 and~~ discharges ~~on and after~~ January 1, 1997*, through December 31, 1998,* shall comply with the Office's standard format and specifications as ~~updated~~ *revised* September 1, 1995*, and discharges on or after January 1, 1999, shall comply with the Office's standard format and specifications as revised in March 1998*. The Office shall furnish each hospital and designated agent a copy of the standard format and specifications before the start of the ~~report~~ *reporting* period to which revisions apply. Additional copies may be obtained at no charge from the Office's Discharge Data Program.

Each hospital ~~(or its agent, if it has designated one),~~ whose discharge data is submitted on computer media *or, if the hospital has designated an agent, that agent*, ~~in whole or part,~~ shall demonstrate its ability to comply with the standard format and specifications by submission of a test file of its data with which the Office can confirm compliance with the standard format and specifications.

~~Such a~~ *The* test file shall be submitted at least 60 days prior to the next reporting period due date by new hospitals or by existing hospitals after a change in any of the following: the Office's standard format and specifications~~,~~*;* the hospital's *or its designated agent's* computer system*, hardware or software* ~~(or that of its designated agent),~~*;* the computer media used by the hospital or its designated agent, the method of ~~submittal~~ *submission* ~~(from Manual Abstract Reporting Form (OSHPD 1370) to computer media),~~*;* or the designated agent, unless the new designated agent has already submitted a test file that complied with the standard format and specifications.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97216. Definition of Data Element—Date of Birth.

The patient's birth date shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and *the* 4-digit year of birth. The numeric form for days and months from 1 to 9 must have a zero as the first digit. When the complete date of birth is unknown, as much of the date as is known shall be reported. At a minimum, an approximate year of birth ~~must~~ *shall* be reported. If only the age is known, ~~report~~ the estimated year of birth *shall be reported*. If the month and year of birth are known, and the exact day is not, ~~report~~ the year*,* ~~and~~ *the* month ~~only~~, and zeros

for the day *shall be reported*.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97217. Definition of Data Element—Sex.

The patient's gender shall be reported as male, female, other, or unknown. "Other" includes sex changes, undetermined sex, and live births with congenital abnormalities that obscure sex identification. "Unknown" indicates that the patient's sex was not available from the medical record.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97218. Definition of Data Element—Race.

Effective with discharges on January 1, 1995, the patient's ethnic and racial background shall be reported as one choice from the following list of alternatives under ethnicity and one choice from the following list of alternatives under race:

(a) Ethnicity:

(1) Hispanic. A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

(2) Non-Hispanic.

(3) Unknown.

(b) Race:

(1) White. A person having origins in or who identifies with any of the original caucasian peoples of Europe, North Africa, or the Middle East.

(2) Black. A person having origins in or who identifies with any of the black racial groups of Africa.

(3) Native American/Eskimo/Aleut. A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

(4) Asian/Pacific Islander. A person having origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. ~~This area includes, for example,~~ *Includes* Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.

(5) Other. Any possible options not covered in the above categories.

(6) Unknown.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97219. Definition of Data Element—ZIP Code.

The "ZIP Code," a unique code assigned to a specific geographic area by the U.S. Postal Service, for the patient's usual residence shall be reported for each patient discharge. Foreign residents shall be ~~coded~~ *reported as* "YYYYY" and unknown ZIP Codes shall be ~~coded~~ *reported as* "XXXXX." If the city of residence is known, but not the street address, report the first three digits of the ZIP Code, and the last two digits as zeros. Hospitals ~~may~~ *shall* distinguish the "homeless" (patients who lack a residence) from other patients lacking a numeric ZIP Code of residence by reporting the ZIP Code of homeless patients as "ZZZZZ." If the patient has a ~~nine-digit~~ *9-digit* ZIP Code, only the first five digits shall be reported.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97220. Definition of Data Element—Patient Social Security Number.

The patient's social security number is to be reported as a ~~nine-digit~~ *9-digit* number. If the patient's social security number is not recorded in the patient's medical record, the social security number shall be reported as "not in medical record," by reporting the social security number as "000000001." The number to be reported is to be the patient's social security number, not the social security number of some other person, such as the mother of a newborn or the insurance beneficiary under whose account the hospital's bill is to be submitted.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

~~**97221. Definition of Data Element--Admission Date.**~~

~~This section, as adopted October 14, 1993, applies to discharges prior to and including December 31, 1996. For Section 97221 applicable to discharges occurring on and after January 1, 1997, see below.~~

~~The patient's date of admission shall be reported in numeric form as follows: the 2-digit month, 2-digit day and final 2 digits of the year. The numeric form for days and months from 1 to 9 must have a zero as the first digit. For discharges representing a transfer of a patient from one level of care within the hospital to another level of care within the hospital, as defined by Subsection (g) of Section 97212 and reported pursuant to Section 97212, the admission date reported shall be the date the patient was transferred to the level of care being reported on this record.~~

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97221. Definition of Data Element—Admission Date.

This section, as amended effective August 14, 1996, applies to discharges on and after January 1, 1997. For Section 97221 applicable to discharges occurring prior to and including December 31, 1996, see above.

The patient's date of admission shall be reported in numeric form as follows: the 2-digit month, *the* 2-digit day, and final 2 digits of the *4-digit* year. The numeric form for days and months from 1 to 9 must have a zero as the first digit. For discharges representing a transfer of a patient from one type of care within the hospital to another type of care within the hospital, as defined by Subsection (g*i*) of Section 97212 and reported pursuant to Section 97212, the admission date reported shall be the date the patient was transferred to the type of care being reported on this record.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97222. Definition of Data Element—Source of Admission.

(a) Effective with discharges occurring January 1, 1995 through December 31, 1996, in order to describe the patient's source of admission, it is necessary to address three aspects of the source: first, the level of care being received by the patient prior to admittance, as indicated by the nature of the site from which the patient originated; second, the license under which the level of care was provided; and, third, the route by which the patient was admitted. One alternative shall be selected from the list following each of three aspects:

(1) Level of care being received by the patient prior to admittance, as indicated by the site from which the patient was admitted.

(A) Home. A patient admitted from the patient's home, the home of a relative or friend, or a vacation site, whether or not the patient was seen at an outpatient clinic or physician's office, or had been receiving home health services or hospice care at home.

(B) Residential Care Facility. A patient admitted from a facility in which the patient resides and that provides special assistance to its residents in activities of daily living, but that provides no organized health care.

(C) Ambulatory Surgery. A patient admitted after treatment or examination in an ambulatory surgery facility, whether hospital-based or a freestanding licensed ambulatory surgery clinic or certified ambulatory surgery center. Excludes outpatient clinics and physicians' offices not licensed and/or certified as an ambulatory surgery facility.

(D) Long-term Care. A patient admitted from skilled nursing care or intermediate

~~care, whether freestanding or hospital-based, or from a Congregate Living Health Facility as defined by Subdivision (i) of Section 1250 of the Health and Safety Code.~~

(E) Acute Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care of a medical/surgical nature, such as in a perinatal, pediatric, intensive care, coronary care, burn, etc., unit of a hospital.

(F) Other Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care not of a medical/surgical nature, such as in a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit.

(G) Newborn. A baby born alive in this hospital.

(H) Prison/Jail. A patient admitted from a correctional institution.

(I) Other. A patient admitted from a source other than mentioned above. Includes patients admitted from: a VA hospital or a freestanding (not hospital-based) inpatient hospice facility.

(2) License under which the level of care was provided.

(A) This Hospital. The Ambulatory Surgery, Long-term Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of this hospital. Includes all newborns.

(B) Another Hospital. The Ambulatory Surgery, Long-term Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of some other hospital.

(C) Not a Hospital. The site from which the patient was admitted was not operated under the license of a hospital. Includes all patients admitted from Home, Residential Care, Prison/Jail, and Other sites. Includes patients admitted from Ambulatory Surgery or Long-term Care sites that were not operated under the authority of the license of any hospital. Excludes all patients admitted from Acute Hospital Care or Other Hospital Care.

(3) Route of admission.

(A) Your Emergency Room. Any patient admitted as an inpatient after being treated or examined in this hospital's emergency room. Excludes patients seen in the emergency room of some other hospital.

(B) Not Your Emergency Room. Any patient admitted as an inpatient without being treated or examined in this hospital's emergency room. Includes patients seen in the emergency room of some other hospital and patients not seen in any emergency room.

(b) Effective with discharges on *or after* January 1, 1997, in order to describe the patient's source of admission, it is necessary to address three aspects of the source: first, the site from which the patient originated; second, the licensure of the site from which the patient originated; and, third, the route by which the patient was admitted. One alternative shall be selected from the list following each of three aspects:

(1*a*) The site from which the patient was admitted.

(A*1*) Home. A patient admitted from the patient's home, the home of a relative or friend, or a vacation site, whether or not the patient was seen at an outpatient clinic or physician's office, or had been receiving home health services or hospice care at home.

(B*2*) Residential Care Facility. A patient admitted from a facility in which the patient resides and that provides special assistance to its residents in activities of daily living, but that provides no organized health care.

(C*3*) Ambulatory Surgery. A patient admitted after treatment or examination in an ambulatory surgery facility, whether hospital-based or a freestanding licensed ambulatory surgery clinic or certified ambulatory surgery center. Excludes outpatient clinics and physicians' offices not licensed and/or certified as an ambulatory surgery facility.

(D*4*) Long-term *Skilled Nursing/Intermediate* Care. A patient admitted from skilled nursing care or intermediate care, whether freestanding or hospital-based, or from a Congregate Living Health Facility, as defined by Subdivision (i) of Section 1250 of the Health and Safety Code.

(E*5*) Acute Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care of a medical/surgical nature, such as in a perinatal, pediatric, intensive care, coronary care, *respiratory care, newborn intensive care, or* burn, etc., unit of a hospital.

(F*6*) Other Hospital Care. A patient who was an inpatient at a hospital, and who was receiving inpatient hospital care not of a medical/surgical nature, such as in a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit.

(G*7*) Newborn. A baby born alive in this hospital.

(H*8*) Prison/Jail. A patient admitted from a correctional institution.

(I*9*) Other. A patient admitted from a source other than mentioned above. Includes patients admitted from: a VA hospital or a freestanding, (not hospital-based), inpatient hospice facility.

(2*b*) Licensure of the site.

(A*1*) This Hospital. The Ambulatory Surgery, Long-term *Skilled Nursing/Intermediate* Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of this hospital. Includes all newborns.

(B*2*) Another Hospital. The Ambulatory Surgery, Long-term *Skilled Nursing/Intermediate* Care, Acute Hospital Care, or Other Hospital Care from which the patient was admitted was operated as part of the license of some other hospital.

(C3) Not a Hospital. The site from which the patient was admitted was not operated under the license of a hospital. Includes all patients admitted from Home, Residential Care, Prison/Jail, and Other sites. Includes patients admitted from Ambulatory Surgery or Long-term *Skilled Nursing/Intermediate* Care sites that were not operated under the authority of the license of any hospital. Excludes all patients admitted from Acute Hospital Care or Other Hospital Care.

(3c) Route of admission.

(A1) Your Emergency Room. Any patient admitted as an inpatient after being treated or examined in this hospital's emergency room. Excludes patients seen in the emergency room of some other *another* hospital.

(B2) Not Your Emergency Room. Any patient admitted as an inpatient without being treated or examined in this hospital's emergency room. Includes patients seen in the emergency room of some other hospital and patients not seen in any emergency room.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97224. Definition of Data Element—Discharge Date.

The patient's date of discharge shall be reported in numeric form as follows: the 2-digit month, the 2-digit day, and the final 2 digits of the *4-digit* year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97225. Definition of Data Element—Principal Diagnosis and Whether the Condition was Present at Admission.

(a) The patient's principal diagnosis, defined as the condition established, after study, to be the chief cause of the admission of the patient to the facility for care, shall be coded according to the International Classification of Diseases, 9th Revision, Clinical Modification, U.S. Department of Health and Human Services, Washington, D.C. (ICD-9-CM), except that psychiatric diagnoses may be coded according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, American Psychiatric Association, Washington, D.C. (DSM IV), Axes I, II, and III.

(b) Effective with discharges on *or after* January 1, 1996, whether the patient's principal diagnosis, even if coded as a V code, was present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97226. Definition of Data Element—Other Diagnoses and Whether the Conditions were Present at Admission.

(a) The patient's other diagnoses are defined as all conditions that coexist at the time of admission, that develop subsequently during the hospital stay, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay are to be excluded. Diagnoses shall be coded according to the ICD-9-CM~~, except that psychiatric diagnoses may be coded according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, American Psychiatric Association, Washington, D.C. (DSM IV), Axes I, II, and III~~. ICD-9-CM codes from the supplementary classification of external causes of injury and poisoning (E800-E999) shall not be reported as other diagnoses.

(b) Effective with discharges on *or after* January 1, 1996, whether the patient's other diagnoses~~, including V codes,~~ were present at admission shall be reported as one of the following:

(1) Yes.

(2) No.

(3) Uncertain.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97227. Definition of Data Element—External Cause of Injury.

The external cause of injury consists of the ICD-9-CM codes E800-E999 (E-codes), that are codes used to describe the external causes of injuries, poisonings, and adverse effects. If the information is available in the medical record, E-codes sufficient to describe the external causes shall be reported for discharges with a principal and/or other diagnoses classified as injuries or poisonings in Chapter 17 of the ICD-9-CM (800-999), or where a code from Chapters 1-16 of the ICD-9-CM (001-799) indicates that an additional E-code is applicable, except that the reporting of E-codes in the range E870-E879 (misadventures and abnormal reactions) are not required to be reported. An E-code is to be reported only for the first inpatient hospitalization during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. To assure uniform reporting of E-codes, when multiple codes are required to completely classify the cause~~(s)~~, the first (principal) E-code shall describe the mechanism that resulted in the most severe injury, poisoning, or adverse effect. If the ~~first~~ *principal* E-code does not include a description of the place of occurrence of the most severe injury or poisoning, an ~~additional~~ E-code shall be reported to designate the place of occurrence, if available in the medical record. ~~Up to three additional~~ *Additional* E-codes shall be reported, if necessary to completely describe the mechanism~~(s)~~ that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect first diagnosed and/or treated during the current inpatient hospitalization.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97228. Definition of Data Element—Principal Procedure and Date.

The patient's principal procedure is defined as one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure. ~~Coding~~ *Procedures* shall be *coded* according to the ICD-9-CM. If only non-therapeutic procedures were performed, then a non-therapeutic procedure should be reported as the principal procedure, if it was a significant procedure. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. The date the principal procedure was performed shall be reported in numeric form as follows: the 2-digit month, *the* 2-digit day, and *the* ~~2-digit~~ *4-digit* year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97229. Definition of Data Element—Other Procedures and Dates.

All significant procedures are to be reported. A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or is needed for DRG assignment. *Procedures shall be coded according to the ICD-9-CM*. The dates shall be recorded with the corresponding other procedures and be reported in numeric form as follows: the 2-digit month, *the* 2-digit day, and *the* ~~2-digit~~ *4-digit* year. The numeric form for days and months from 1 to 9 must have a zero as the first digit.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97230. Definition of Data Element—Total Charges.

The total charges are defined as all charges for services rendered during the length of stay for patient care at the facility, based on the hospital's full established rates. Charges shall include, but not be limited to, daily hospital services, ancillary services, and any patient care services. Hospital-based physician fees shall be excluded. Prepayment (e.g., deposits and prepaid admissions) shall not be deducted from Total Charges. If a patient's length of stay is more than 1 year (365 days), ~~record~~ *report* Total Charges for the last year (365 days) of stay only.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97231. Definition of Data Element—Disposition of Patient.

(a) Effective with discharges occurring January 1, 1995 through December 31, 1996, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the facility, shall be reported as one of the following:

(1) Routine Discharge. A patient discharged from this hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office, or a clinic shall be included. Excludes patients referred to a home health service.

(2) Acute Care Within This Hospital. A patient discharged to inpatient hospital care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, etc. unit within this reporting hospital.

(3) Other Type of Hospital Care, Within This Hospital. A patient discharged to inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit within the reporting hospital.

(4) Long-term Care Within This Hospital. A patient discharged to a Skilled Nursing/Intermediate Care Distinct Part within this reporting hospital.

(5) Acute Care at Another Hospital. A patient discharged to another hospital to receive inpatient care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive, coronary, respiratory, newborn intensive care, or burn unit of another hospital.

(6) Other Type of Hospital Care at Another Hospital. A patient discharged to another hospital to receive inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit of another hospital.

(7) Long-term Care Elsewhere. A patient discharged from this hospital to a Skilled Nursing/Intermediate Care level of care, either freestanding or a distinct part within some other hospital, or to a Congregate Living Health Facility as defined by Subdivision (i) of Section 1250 of the Health and Safety Code.

(8) Residential Care Facility. A patient discharged to a facility that provides special assistance to its residents in activities of daily living, but that provides no organized health care.

(9) Prison/Jail. A patient discharged to a correctional institution.

(10) Against Medical Advice. Patient left the hospital against medical advice, without a physician's discharge order. Psychiatric patients discharged from AWOL status are included in this category.

(11) Died. All episodes of inpatient care that terminated in death. Patient expired after admission and before leaving the hospital.

(12) Home Health Service. A patient referred to a licensed home health service program.

(13) Other. A patient discharged to some place other than mentioned above. Includes patients discharged to a VA facility or to an inpatient hospice facility that is not part of a hospital.

(b) Effective with discharges on *or after* January 1, 1997, the patient's disposition, defined as the consequent arrangement or event ending a patient's stay in the *reporting* facility, shall be reported as one of the following:

(1*a*) Routine Discharge. A patient discharged from this hospital to return home or to another private residence. Patients scheduled for follow-up care at a physician's office, or a clinic shall be included. Excludes patients referred to a home health service.

(2*b*) Acute Care Within This Hospital. A patient discharged to inpatient hospital care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive care, *coronary care, respiratory care, newborn intensive care, or burn* etc. unit within this reporting hospital.

(3*c*) Other Type of Hospital Care Within This Hospital. A patient discharged to inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit within the *this* reporting hospital.

(4*d*) Long-term *Skilled Nursing/Intermediate* Care Within This Hospital. A patient discharged to a Skilled Nursing/Intermediate Care Distinct Part within this reporting hospital.

(5*e*) Acute Care at Another Hospital. A patient discharged to another hospital to receive inpatient care that is of a medical/surgical nature, such as to a perinatal, pediatric, intensive *care*, coronary *care*, respiratory *care*, newborn intensive care, or burn unit of another hospital.

(6*f*) Other Type of Hospital Care at Another Hospital. A patient discharged to another hospital to receive inpatient hospital care not of a medical/surgical nature and not skilled nursing/intermediate care, such as to a psychiatric, physical medicine rehabilitation, or chemical dependency recovery treatment unit of another hospital.

(7*g*) Long-term *Skilled Nursing/Intermediate* Care Elsewhere. A patient discharged from this hospital to a Skilled Nursing/Intermediate Care type of care, either freestanding or a distinct part within some other *another* hospital, or to a Congregate Living Health Facility, as defined by Subsection (i) of Section 1250 of the Health and Safety Code.

(8*h*) Residential Care Facility. A patient discharged to a facility that provides special assistance to its residents in activities of daily living, but that provides no organized health care.

(9*i*) Prison/Jail. A patient discharged to a correctional institution.

(10*j*) Against Medical Advice. Patient left the hospital against medical advice, without a physician's discharge order. Psychiatric patients discharged from *away without leave (*AWOL*)* status are included in this category.

(11*k*) Died. All episodes of inpatient care that terminated in death. Patient expired after admission and before leaving the hospital.

(12*l*) Home Health Service. A patient referred to a licensed home health service program.

(13*m*) Other. A patient discharged to some place other than mentioned above. Includes patients discharged to a VA facility or to an *freestanding, not hospital-based,* inpatient hospice facility that is not part of a hospital.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97232. Definition of Data Element—Expected Source of Payment.

(a) Effective with discharges on *occurring* January 1, 1995, *through December 31, 1998,* the patient's expected principal source of payment, defined as the source that is expected to pay the greatest share of the patient's bill, shall be reported using the following categories:

(a*1*) Medicare. Defined by Title XVIII of the Social Security Act (42 USC 1395 et seq.) and Title I of the Federal Medicare Act (PL 89-97). Includes crossovers to secondary payers. Report Medicare patients covered under an HMO or PPO arrangement as Medicare.

(b*2*) Medi-Cal. Defined by Title XIX of the Social Security Act and Title I of the Federal Medicare Act (PL 89-97). Report Medi-Cal patients covered under an HMO or PPO or other type of managed care arrangement as Medi-Cal.

(c*3*) Workers' Compensation. Payment from Workers' Compensation insurance.

(d*4*) County Indigent Programs. Any payment from county funds, whether from county general funds or from other funds used to support county health programs. Includes County Medical Services Program (CMSP), California Health Care for Indigent Program (CHIP), etc.

(e*5*) CHAMPUS/CHAMPVA/VA. Any payment from the Civilian Health and Medical Program of the Uniformed Services or the Civilian Health and Medical Program of the Veterans Administration, or the Veterans Administration.

(f*6*) Other Governmental. Any form of payment from American government agencies, whether local, state, or federal, except those listed above. Coded here are California Children Services (CCS), Title V, and Short-Doyle. Exclude payment by governments of other countries, such as Canada, Kuwait, etc.

(g*7*) Health Maintenance Organization (HMO). Report Medicare patients covered under an HMO arrangement as Medicare. Report Medi-Cal patients covered under an HMO arrangement as Medi-Cal.

(h*8*) Preferred Provider Organization (PPO). Report Medicare patients covered under a PPO arrangement as Medicare. Report Medi-Cal patients covered under a PPO arrangement as Medi-Cal.

(i*9*) Private Insurance Company (non-HMO, non-PPO). Payment covered by any private or commercial insurance carrier, not under an HMO or PPO basis.

(j*10*) Blue Cross/Blue Shield (non-HMO, non-PPO). Payment covered by a Blue Cross/Blue Shield plan, not under an HMO or PPO basis.

(k*11*) Self Pay. Payment directly by the patient, guarantor, relatives or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other third party.

(l*12*) Charity Care. A patient receiving care pursuant to Hill Burton obligations or who meets the standards for charity care pursuant to the hospital's established charity care policy.

(m*13*) No Charge. No charge will be made by the facility. Coded here are free, special research, or courtesy patients.

(n*14*) Other Non-governmental. Any third party payment not included in the above options. Coded here are payment by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, Shriners, etc., and payments by other countries.

Where payment is under a self-insured or self-funded plan, the category to be used is the one most descriptive of the third-party administrator. For example, if the self-insured or self-funded plan is administered by Blue Cross/Blue Shield, then Blue Cross/Blue Shield should be reported as the expected source of payment; if the third-party administrator is an HMO, then HMO should be reported as the source; similar choices should be made if the third-party administrator is a PPO or Private Insurance Company.

(b) Effective with discharges on or after January 1, 1999, the patient's expected source of payment shall be reported using the following:

(1) Payer Category: The type of entity or organization which is expected to pay or did pay the greatest share of the patient's bill.

(A) Medicare. A federally administered third party reimbursement program authorized by Title XVIII of the Social Security Act. Includes crossovers to secondary payers.

(B) Medi-Cal. A state administered third party reimbursement program authorized by Title XIX of the Social Security Act.

(C) Private Coverage. Payment covered by private, non-profit, or commercial health plans, whether insurance or other coverage, or organizations. Included are payments by local or organized charities, such as the Cerebral Palsy Foundation, Easter Seals, March of Dimes, Shriners.

(D) Workers' Compensation. Payment from workers' compensation insurance, government or privately sponsored.

(E) County Indigent Programs. Patients covered under Welfare and Institutions Code Section 17000. Includes programs funded in whole or in part by County Medical Services Program (CMSP), California Healthcare for Indigents Program (CHIP), and/or Realignment Funds for which the hospital renders to the county a bill or other claim for payment.

(F) Other Government. Any form of payment from government agencies, whether local, state, federal, or foreign, except those in Subsections (b)(1)(A), (b)(1)(B), (b)(1)(D), or (b)(1)(E) of this section. Includes funds received through the California Children Services (CCS), the Civilian Health and Medical Program of the Uniformed Services (TRICARE), and the Veterans Administration.

(G) Other Indigent. Patients receiving care pursuant to Hill-Burton obligations or who meet the standards for charity care pursuant to the hospital's established charity care policy. Includes indigent patients, except those described in Subsection (b)(1)(E) of this section.

(H) Self Pay. Payment directly by the patient, personal guarantor, relatives, or friends. The greatest share of the patient's bill is not expected to be paid by any form of insurance or other health plan.

(I) Other Payer. Any third party payment not included in Subsections (b)(1)(A) through (b)(1)(H) of this section. Included are cases where no payment will be required by the facility, such as special research or courtesy patients.

(2) Type of Coverage. For each Payer Category, Subsections (b)(1)(A) through (b)(1)(F) of this section, select one of the following Types of Coverage:

(A) Managed Care - Knox-Keene/Medi-Cal County Organized Health System. Health care service plans, including Health Maintenance Organizations (HMO), licensed by the Department of Corporations under the Knox-Keene Health Care Service Plan Act of 1975. Includes Medi-Cal County Organized Health Systems.

(B) Managed Care - Other. Health care plans, except those in Subsection (b)(2)(A) of this section, which provide managed care to enrollees through a panel of providers on a pre-negotiated or per diem basis, usually involving utilization review. Includes Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Exclusive Provider Organization with Point-of-Service option (POS).

(C) Traditional Coverage. All other forms of health care coverage, including the Medicare prospective payment system, indemnity or fee-for-service plans, or other fee-for-service payers.

(3) Name of Plan. The names of those plans which are licensed under the Knox-Keene Health Care Service Plan Act of 1975 or designated as a Medi-Cal County Organized Health System. For Type of Coverage, Subsection (b)(2)(A) of this section, report the plan code number

representing the name of the Knox-Keene licensed plan as shown in Table 1 or the Medi-Cal County Organized Health System as shown in Table 2.

Table 1. Knox-Keene Licensed Plans and Plan Code Numbers

Plan Code Names	Plan Code Numbers
Aetna Health Plans of California	0176
Alameda Alliance for Health	0328
Blue Cross of California	0303
Blue Shield of California	0043
BPS HMO	0314
Brown and Toland Medical Group	0352
Care 1st Health Plan	0326
Careamerica-Southern California, Inc.	0234
Chinese Community Health Plan	0278
Cigna Healthcare of California, Inc.	0152
CMG Behavioral Health of Calif., Inc.	0312
Community Health Group	0200
Community Health Plan (County of Los Angeles)	0248
Contra Costa Health Plan	0054
Concentrated Care	0360
FPA Medical Management of California	0350
Foundation Health, a California Health Plan	0109
Great American Health Plan	0327
Greater Pacific HMO, Inc.	0317
HAI	0292
Healthmax America	0277
Health Net	0300
Health Plan of America (HPA)	0126
Health Plan of the Redwoods	0159
Heritage Provider Network, Inc.	0357
Inland Empire Health Plan	0346
Inter Valley Health Plan	0151
Kaiser Foundation Added Choice Health Plan	0289
Kaiser Foundation Health Plan, Inc.	0055
Kern Health Systems, Inc.	0335
Key Health Plan of California	0343
Lifeguard, Inc.	0142
Local Initiative Health Authority for LA County	0355
Managed Health Network, Inc.	0196
Maxicare	0002
MCC Behavioral Care of California, Inc.	0298
MedPartners Provider Network, Inc.	0345
Metrahealth Care Plan	0266
Merit Behavioral Care of California, Inc.	0288

Molina Medical Centers	*0322*
Monarch Plan, Inc.	*0270*
National Health Plans	*0222*
National HMO	*0222*
Occupational Health Services (OHS)	*0235*
Omni Healthcare, Inc.	*0238*
One Health Plan of California, Inc.	*0325*
Pacificare Behavioral Health of California, Inc.	*0301*
Pacificare of California	*0126*
Priority Plus of California	*0237*
Prucare Plus	*0296*
Qualmed Plans for Health	*0300*
Regents of the University of California	*0354*
San Francisco Health Plan	*0349*
Santa Clara County Family Health Plan	*0351*
Secure Horizons	*0126*
Sharp Health Plan	*0310*
Smartcare Health Plan	*0212*
The Health Plan of San Joaquin	*0338*
Tower Health Service	*0324*
United Healthcare of California, Inc. (UHC Healthcare)	*0266*
UHP Healthcare	*0008*
Universal Care	*0209*
Valley Health Plan (Santa Clara County)	*0236*
Value Behavioral Health of California, Inc.	*0293*
Ventura County Health Care Plan	*0344*
Vista Behavioral Health Plan	*0102*
Western Health Advantage	*0348*
Other	*8000*

Table 2. Medi-Cal County Organized Health Systems and Plan Code Numbers

Name of Medi-Cal County Organized Health System	*Plan Code Numbers*
Orange County	*9030*
San Mateo County	*9041*
Santa Barbara County	*9042*
Santa Cruz County	*9044*
Solano County	*9048*

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97233. Definition of Data Element—Prehospital Care and Resuscitation.

Effective with discharges on or after January 1, 1999, information about resuscitation orders in a patient's current medical record shall be reported as follows:

(a) Yes, a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital.

(b) No, a DNR order was not written at the time of or within the first 24 hours of the patient's admission to the hospital.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97239. Hospital Identification Number.

~~Effective with discharges through December 31, 1994, the unique nine-digit hospital identification number used by the Office's Discharge Data Program shall be reported for each patient record, either on the Individual Hospital Transmittal Form (OSHPD 1370.1) that must accompany data submitted on the Manual Abstract Reporting Form (OSHPD 1370), or in positions 1 through 9 of computer media format.~~ Effective with discharges on *or after* January 1, 1995, the last six digits of the ~~existing nine-digit~~ *9-digit* identification number *assigned by the Office* shall be reported as part of each patient record, either in the specified section of the Manual Abstract Reporting Form (OSHPD 1370)~~,~~ or in positions 2 through 7 on computer media format.

Authority: Section 128765, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97240. Request for Modifications to the California Hospital Discharge Data Set.

(a) Hospitals may file a request with the Office for modifications to the California Hospital Discharge Data Set. The modification request must be supported by a detailed justification of the hardship that full reporting of discharge data would have on the hospital; an explanation of attempts to meet discharge data reporting requirements; and a description of any other factors that might justify a modification. Modifications may be approved for only one year. Each hospital with an approved modification must request a renewal of that approval 60 days prior to termination of the approval period in order to have the modification continue in force.

(b) The criteria to be considered and weighed by the Office in determining whether a modification to discharge data reporting requirements may be granted are as follows:

(1) The modification would not impair the ability of either providers or consumers to make informed health care decisions.

(2) The modification would not deprive the public of *discharge* data needed to make comparative choices with respect to scope or type of services or to how services are provided, and with respect to the manner of payment.

(3) The modification would not impair any of the goals of the Act.

Authority: Section 128810, Health and Safety Code.
Reference: Sections 128735 and 128760, Health and Safety Code.

97241. Requests for Extension of Time to File Discharge Data.

Extensions are available to hospitals that are unable to complete their submission of discharge data reports by the due date prescribed in Section 97211. A maximum of 60 days is allowed for all extensions, corrections, and resubmittals. Hospitals are encouraged to file extension requests as soon as it is apparent that the required data will not be completed for submission on or before their due date. The request for extension shall be postmarked on or before the required due date of the discharge data report and supported by a letter of justification that may provide good and sufficient cause for the approval of the extension request. To provide the Office a basis to determine good and sufficient cause, the letter of justification shall include a factual statement indicating:

(1) the actions taken by the hospital to produce the discharge data report by the required deadline;

(2) those factors that prevent completion of the discharge data report by the deadline; and

(3) those actions and the time (days) needed to accommodate those factors.

The Office shall respond within 10 days of receipt of the request by either granting what is determined to be a reasonable extension or disapproving the request. If disapproved, the Office shall set forth the basis for a denial in a notice to the hospital sent by certified mail. The Office may seek additional information from the requesting hospital. The Office shall not grant extensions that exceed an accumulated total of 60 days for all extensions and corrections of discharge data. If a hospital submits the discharge data report prior to the due date of an extension, those days not used will be applied to the number of remaining extension days. A hospital that wishes to contest any decision of the Office shall have the right ~~of~~ *to* appeal, ~~as provided by~~ *pursuant to* Section 97052.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97242. Error Tolerance Levels.

(a) The error tolerance levels for discharge data items reported to the Office shall be as shown in Table 1. An error percentage that exceeds a specified error tolerance level shall be corrected by the hospital to the specified tolerance level.

(b) For error ~~tolerance levels~~ *percentages* for *the data elements* ~~"admission date"~~ *Admission Date* and ~~"discharge date"~~ *Discharge Date* that do not exceed the error tolerance levels specified in Table 1, the Office shall delete ~~the hospital's entire~~ *each* record *with an error in one of these data elements from the hospital's report* if the hospital fails to correct the data after a 30 calendar day

notification by the Office of the error(s).

(c) Effective with discharges occurring *on or after* July 1, 1990, and thereafter, for error tolerance levels *percentages* for data elements other than "admission date" *Admission Date* and "discharge date" *Discharge Date* that do not exceed the error tolerance levels specified in Table 1, the Office shall assign default values *of blank, which may be represented by a zero, except that for the data element Whether the Condition was Present at Admission for the Principal Diagnosis the Office shall assign the default value of Yes,* as shown in Table 2 if the hospital fails to correct the data after a 30 calendar day notification by the Office of the error(s).

Table 1. Discharge Data Error Tolerance Levels

Data Element	Error Tolerance Level
Date of Birth	.1%
Sex	.1%
Race	5%
ZIP Code	5%
Patient Social Security Number	.1%
Admission Date	.1%
Source of Admission	5%
Type of Admission	5%
Discharge Date	.1%
Principal Diagnosis	.1%
Condition Present at Admission for Principal Diagnosis = Present at Admission	.1%
Other Diagnoses	.1%
Condition Present at Admission for Other Diagnoses = Present at Admission	.1%
External Cause of Injury	.1%
Principal Procedure	.1%
Principal Procedure Date	1%
Other Procedures	.1%
Other Procedures Dates	1%
Total Charges	.1%
Disposition of Patient	1%
Expected Principal Source of Payment	.1%
Prehospital Care and Resuscitation	*.1%*

Table 2. Discharge Data Error Tolerance Level Default Values

Data Element	*Default Value*
Date of Birth	0
Sex	[unknown]
Race	[unknown]
ZIP Code	XXXXX
Social Security Number	000000001

Source of Admission	0
Type of Admission	[unknown]
Principal Diagnosis	799.9
Principal Diagnosis - Present at Admission	Yes
Other Diagnoses	[blank]
Other Diagnoses - Present at Admission	Uncertain
External Cause of Injury	[blank]
Principal Procedure	[blank]
Principal Procedure Date	0
Other Procedures	[blank]
Other Procedures Dates	0
Total Charges	0
Disposition of Patient	0
Expected Principal Source of Payment	0

(d)(1) The error tolerance level *percentage* of *for the data element* "sex" *Sex* shall include "unknown." *unknown sex*.

(2) The error tolerance level *percentage* for *the data element* "race" *Race* shall include "unknown." *unknown race*.

(3) The error tolerance level *percentage* for *the data element* "ZIP code" *ZIP Code* shall include "partial and unknown." *partial and unknown ZIP codes*.

(4) The error tolerance level *percentage* for *the data element* "type of admission" *Type of Admission* shall include "unknown." *unknown type of admission*.

(5)(a) The error tolerance level *percentages* for both *the data elements* "principal diagnosis" *Principal Diagnosis* and "other diagnoses" *Other Diagnoses* shall, for any one record, count all errors made in coding diagnoses as one error.

(b*6*) The error tolerance level *percentages* for *the data elements* "principal diagnosis - present at admission" *Condition Present at Admission for Principal Diagnosis* and "other diagnoses - present at admission" *Condition Present at Admission for Other Diagnoses* shall, for any one record, count all errors made as one error.

(6*7*) The error tolerance level *percentages* for both *the data elements* "principal procedure" *Principal Procedure* and "other procedures" *Other Procedures* shall, for any one record, count all errors made in coding procedures as one error.

(7*8*) The error tolerance level *percentages* for both *the data elements* "principal procedure date" *Principal Procedure Date* and "other procedure dates" *Other Procedures Dates* shall, for any one record, count all errors made in coding date as one error.

(8) The error tolerance level for "social security number" shall include "blank" and "invalid."

(9) The error ~~tolerance level~~ *percentage* for *the data element* ~~"external cause of injury"~~ *External Cause of Injury* shall~~, include "invalid."~~ *for any one record, count all errors made in coding diagnoses as one error*.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.

97243. Acceptance Criteria.

(a) The discharge data report shall not be accepted but shall be rejected and returned to the hospital by the Office~~,~~ if the following requirements are not met:

(1) ~~A~~ *Submission of a* completed ~~and appropriate~~ transmittal form ~~must be submitted~~ with the discharge data report, pursuant to Section 97214.

(2) ~~If the data are submitted on computer media, the hospital or its agent, if the hospital has designated one, shall have demonstrated~~ ~~compliance~~ *Compliance* with the Office's standard format and specifications, *demonstrated* by *the hospital or its designated agent* having previously submitted a set of data that the Office approved as being in conformance to the applicable standard format and specifications, pursuant to Section 97215.

(3) *Submission of* ~~The~~ *the* appropriate version of the Manual Abstract Reporting Form (OSHPD 1370), as specified in Section 97215, ~~must be used~~ when reporting other than on computer ~~tape (reel or cartridge) or diskette~~ *media*.

(4) *Submission by* ~~The~~ *the* hospital~~,~~ *or by its* designated agent~~, data processing firm, or other third party submitting the data must be~~ in accordance with the most recent designation furnished by the hospital to the Office, pursuant to Section 97210.

(b) After a discharge data report ~~submitted on computer media~~ is accepted, the hospital may be required to *correct and/or* replace the data~~, after having corrected data and other problem(s),~~ if any of the following circumstances pertain:

(1) The Office ~~was~~ *is* unable to read the computer media submitted.

(2) When the computer *medium data* file ~~was~~ *is* read, it ~~contained~~ *contains* no data, ~~contained~~ *contains* data not covering the full reporting period, or ~~contained~~ *contains* ~~fewer~~ *a different number of* records *in the file* than *the number of records* stated on the transmittal form.

(3) The data ~~were~~ *are* not reported in compliance with Section 97215 ~~(standard format and specifications)~~.

(4) The hospital identification number on each of the records being reported for the hospital does not agree with that hospital's identification number specified on the transmittal form, pursuant to Section 97214.

(5) Over 600 corrections *Corrections* are required as a result of not meeting the Office's *requirements of Section 97213; not meeting the* data element definitions*, as* specified in Sections 97216 through 97232 *97233,; and/or not meeting the error tolerance levels, as specified in Table 1 of Section 97242.* editing criteria as set forth in the Office's "Discharge Data Program Editing Criteria Handbook," as revised. Any hospital or other interested party may obtain a free copy of the current version of the "Discharge Data Program Editing Criteria Handbook," from the Office's Discharge Data Program. The Office shall send a copy of the current version of the "Discharge Data Program Editing Criteria Handbook," along with the request for replacement, if the contents are relevant to the reasons the replacement is requested.

(c) After a discharge data report is accepted, the hospital may be required to supply corrections if any of the following circumstances pertain:

(1*6*) All inpatient discharges, as defined by Subsection (*cd*) of Section 97212, were not reported.

(2) Between 75 and 600 records require correction as a result of not meeting the Office's data element definitions specified in Sections 97216 through 97232, and editing criteria as set forth in the Office's "Discharge Data Program Editing Criteria Handbook," as revised. Any hospital or other interested party may obtain a free copy of the current version of the "Discharge Data Program Editing Criteria Handbook," from the Office's Discharge Data Program. The Office shall send a copy of the current version of the "Discharge Data Program Editing Criteria Handbook," along with the request for corrections, if the contents are relevant to the reasons the corrections are requested.

(d*c*) If a hospital is required to replace or correct their discharge data, the Office shall allow a specified number of days for correction or replacement and shall establish a due date for resubmittal of the corrections or replacement. In determining the number of days to be allowed, the Office shall take account of the number and degree of errors and the number of extension days already granted, but in no case shall an aggregate total of more than 60 days for all extensions, corrections, replacements, and resubmittals be allowed.

Authority: Section 128810, Health and Safety Code.
Reference: Section 128735, Health and Safety Code.